TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
AMERICAN SPECIALTY PHARMACY

Respondent Name
EMPLOYERS MUTUAL CASUALTY CO

MFDR Tracking Number
M4-15-2449

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 7, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Amount in Dispute: $3,022.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The compound drugs required preauthorization. Preauthorization was not requested."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 11, 2014	Prescription Medication (Compound Cream)	$3,022.44	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.540 sets out the guidelines for use of the closed formulary for claims subject to certified networks.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 197 – Precertification/authorization/notification absent.
   - 96 – Non-covered charge(s).

Issues
Is the insurance carrier's reason for denial of payment supported?

Findings

The insurance carrier denied disputed services with denial code "197 – PERCERTIFICATION/ AUTHORIZATION/ NOTIFICATION ABSENT." 28 Texas Administrative Code §134.540 (b) states, in relevant part, "Preauthorization for claims subject to the Division's closed formulary. Preauthorization is only required for: … (2) any compound that contains a drug identified with a status of 'N' in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates."

Review of the submitted documentation finds that the dispute involves a compound drug that includes the ingredients; Flurbiprofen, Ketamine, Lidocaine, Gabapentin, Ethoxy Diglycol, Propylene Glycol, and Versapro Cream. The *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary* in effect for date of service December 11, 2014, finds that Ketamine and Lidocaine are "N" status drugs. Therefore, the disputed service requires preauthorization.

28 Texas Administrative Code §134.540 (e)(1) states, "For situations in which the prescribing doctor determines and documents that a drug excluded from the closed formulary is necessary to treat an injured employee's compensable injury and has prescribed the drug, the prescribing doctor, other requestor, or injured employee must request approval of the drug in a specific instance by requesting preauthorization in accordance with the certified network's preauthorization process established pursuant to Chapter 10, Subchapter F of this title (relating to Utilization Review and Retrospective Review) and applicable provisions of Chapter 19 of this title (relating to Agents' Licensing)." Review of the submitted documentation does not support that preauthorization was requested or obtained. Therefore, the Division finds that the insurance carrier's denial reason is supported. As a result, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		August 5, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.